



Conclusions

A new and unprecedented disease. AIDS was a completely new and unprecedented disease—one that spread silently and rapidly, and then killed its victims 10 years later. It was and still is enormously stigmatized because of the way it is spread. Even as neighboring countries were hit, there was denial virtually everywhere and insistence that the conditions were different in “my country.” At the same time, while HIV was spreading rapidly, weak health systems in developing countries were faced with enormous demand from afflictions and people who were dying now.

Without a better understanding of the true levels of infection and risk behavior, AIDS was assumed to be primarily an urban disease in Africa, where two-thirds of the population was rural. Many in the Bank were deeply concerned that a call for AIDS programs might divert scarce resources from programs to strengthen weak health systems. They did not fully realize the impact that this epidemic would eventually have on mortality and on the health system itself. Despite important developments in treatment, AIDS was—and remains—an affliction that is incurable and expensive to treat. This adds to the stigma surrounding it and the reluctance to allocate resources to treatment.

Lessons of the first generation of World Bank assistance. During the first phase of the Bank’s response, projects were developed based on client demand and the initiative of

concerned staff, often in collaboration with the Global Program on AIDS. The Bank committed more than \$500 million to countries on four continents for free-standing AIDS projects, large AIDS components, and many activities embedded less formally in health projects. In many of the countries where it was active, the Bank helped to build national institutions for the long-run response to AIDS, strengthened the activities of Ministries of Health, and assisted governments in strategic thinking, while keeping an eye on prevention and the main drivers of the epidemic, even when the latter was controversial. Awareness was raised, condoms were provided, NGOs were enlisted, health staff was trained. But both commitment and implementation capacity often were overestimated, reducing efficacy below what might have been achieved. Important information-oriented activities on HIV infection, behavior,

and the efficacy of interventions were often delayed, poorly supervised, or not implemented because of the perceived urgency of the problem and the need to get disbursements going. This not only reduced the learning and possible improvements in efficiency, but in many instances delayed policy makers' awareness of the problem. Many innovations were "tested," but few if any were evaluated, limiting learning by doing.

The main impediments to more effective global action by the Bank in containing the spread of HIV in the 1990s were low demand by the Bank's borrowers and the delay by health sector management in recognizing the longer-run threat of AIDS to health and to fragile health systems in the countries that were hardest hit. **Two main lessons coming out of the first phase pertained to the importance of generating and sustaining political commitment and the need to produce information to reduce the uncertainty surrounding the disease and to lead to locally adapted responses.**

Preliminary lessons from the Africa MAP.

The concept underlying the Africa MAP of a line of credit for well-prepared programs to fight AIDS is sound, and the announcement of a significant envelope of potential funds for AIDS may have been an important signal to reluctant governments of the Bank's commitment. In the late 1990s, Bank management came to understand the bottleneck of low commitment by clients and the severity of the disease, which reduced life expectancy in the hardest-hit countries to levels from the 1950s. As a result, the MAP placed enormous emphasis in its eligibility criteria and its program design on the mobilization of top leaders, all sectors of the economy, and civil society. This was backed by strong commitment and engagement from within the Bank, as AIDS became much more prominent in CASSs. There has been a tremendous turnaround in the willingness to act, not only in the countries and the Bank, but also among the international community. The demand constraint was further eased by the approval of IDA grants in September 2002.

The sense of urgency led the MAP to rely heavily on "template" strategies and institutions, and to focus on mobilization and implementation over content. The project design addressed the risks associated with weak political commitment and implementation capacity, but neglected other important risks linked to relevance, efficiency, and efficacy of the Bank's assistance. Individual projects may have reduced these risks, such as by enhancing the role of the Ministry of Health or creating components on priority activities. The Bank's ACTAfrica team identified many of these unanticipated risks and has intervened to minimize them. The extent to which these efforts have succeeded will not be known until ongoing projects can be assessed after their completion.

There is evidence for some concern about these risks in the implementation to date, however. The emphasis on quick preparation often resulted in delays in implementation—a lesson that has been well learned throughout the Bank's broader portfolio, and even in previous AIDS projects.¹ National strategic plans—the blueprint for how MAP resources are to be spent—in many cases have not been sufficiently prioritized to guide the allocation of scarce human resources. Stronger M&E and "learning by doing" that were supposed to ensure efficacy and efficiency have not fully materialized. By and large, what is being scaled up has not been locally evaluated. The objectives of the engagement of the wide array of mobilized actors—central ministries, local government, NGOs, CBOs, the private sector, and communities—are not always clear. The activities supported do not necessarily reflect programmatic priorities or a comparative advantage in implementation. To date, there is little information about the coverage and quality of services, the extent to which they compete with or complement efforts by local government, or the sustainability of activities. Like the portfolio of completed projects, preventive programs for the general population are being supplied, while public goods and prevention among the epidemiologically most relevant populations are not being addressed

to the extent that they should be. The mechanisms used to mobilize the population have dramatically increased the complexity of the projects and, in some cases, failed to strengthen or even alienated the Ministry of Health, the lead agency in the response.

In parallel with the Africa MAP, other Regions of the Bank have expanded HIV/AIDS assistance to countries with nascent and concentrated epidemics, largely without the signaling effect of a MAP or the need to shorten preparation.² These efforts have benefited from an international environment that has put more pressure on governments to address AIDS. In large countries, such as Brazil, China, India, and Russia, the Bank's assistance is small in relation to total health spending, but has been used to encourage emphasis on public goods, prevention, and the need to extend access to those most likely to contract and spread the virus.

AIDS is a long-run problem. The AIDS epidemic is wreaking havoc in the hardest-hit countries now, but it is a long-run problem. It demands a mix of actions, some designed for rapid impact and others focused on building long-term capacity and sustainability. Immediate action is imperative to prevent future infections—the only way at present to reduce the scope of the epidemic and its impact—and to ensure care and support for those who have fallen ill. Most of the people who will fall ill over the next decade have already been infected. This presents a predictable impact on health care needs, although the treatment environment is rapidly changing.

In addition to efficient and effective short-run responses, developing countries need support for creating strong national and subnational institutions and mechanisms to respond to the long-run problem, not only by dramatically expanding HIV/AIDS prevention (which remains politically difficult), but also by strengthening the ability of health systems to deliver care to AIDS patients and to address other health problems, by strengthening social safety nets to help those affected, and by ensuring sustainability of these efforts. There will be a continuing need to develop and maintain

political commitment within countries at all levels and across all sectors.

AIDS demands both short-run action and long-term capacity building.

Future directions of the Bank's HIV/AIDS assistance.

Throughout the 1990s and up to the present, the World Bank has been the largest external provider of AIDS assistance to developing countries. This is about to change. Since 2000, there has been an enormous mobilization of resources for AIDS by the international community, primarily for treatment. Not only have the Bank's commitments dramatically increased, by nearly \$2 billion; the Global Fund to Fight AIDS, TB, and Malaria (GFATM) has committed \$1.6 billion³ to financing anti-AIDS efforts in developing countries—roughly doubling AIDS assistance in African countries where the Bank is already active (see table 5.1).

In addition, the U.S. government has announced its intent to direct a total of \$15 billion over 5 years to 15 countries in Africa, Asia, and the Caribbean, primarily for treatment and care. The Gates and Clinton Foundations have pledged hundreds of millions of dollars. Indeed, the concern of the health community in the early 1990s that AIDS might sideline broader health sector development may be coming to pass in the most severely affected countries. The GFATM AIDS commitments to Rwanda and Uganda on an annual basis exceed the recurrent budget of the Ministry of Health.⁴ The Bank and the President's Emergency Program for HIV/AIDS Relief (PEPFAR) are also financing these countries. Although in some cases the pledged resources from other donors have not yet been received, the ability to absorb this level of resources and to use them effectively needs critical examination, as does the balance between AIDS and health spending and the sustainability of the investments being made. While most donors are investing in long-run capacity building, in the short run they are all drawing on the same pool of relatively fixed capacity. The prioritization of scarce national capacity in the short run needs to be addressed in every country.

With its long-run commitment to poverty alleviation, its unique relationship with national governments, its analytic strengths, and its multisectoral reach, the Bank's comparative advantage is to help countries build robust institutions adapted to local political and social realities; to assess alternatives; and help to improve the efficacy, efficiency, and sustainability of AIDS efforts in the long term. The crucial importance of political commitment is now recognized, though the need to constantly renew and broaden commitment may still be underestimated. The vital needs for timely information; prioritization of activities; and information to design, monitor, evaluate, and improve programs are still not fully appreciated.

To be effective, the Bank will need to focus on greater use of information and evaluation, helping governments to link decisions to evidence and to assess alternatives and set priorities. Programmatically it must continue to press for broadened political commitment and maintain a focus on

Bank and borrower efforts need to be more evidence-based, to enhance development effectiveness.

public goods and prevention, particularly among those most likely to contract and spread HIV, in countries at all stages of the epidemic. In the hardest-hit countries, the

Bank must act to improve the efficiency and sustainability of AIDS treatment in health systems and strengthen programs to integrate orphans and other severely affected groups into national safety net and anti-poverty measures.

Partnerships. The Bank worked closely with the WHO/GPA in the early years for technical input and currently is collaborating with UNAIDS, as well as agencies such as the U.S. CDC. Much of the Bank's ongoing assistance to governments is parallel to, in coordination with, and often cofinanced with bilateral and multilateral donors. Increasingly, supervision is conducted through joint reviews with other donors and government.

Harmonization of procedures at the country level will reduce the burden on governments of dealing with the different reporting requirements of multiple international agencies. The World Bank has endorsed the "Three Ones" policy of one national authority, one strategy, and one M&E system. It is not enough to obtain agreement, however; what is agreed upon must also be shown to improve the efficiency and impact of programs in each country. The Bank and its international partners bear some responsibility, for example, for promoting template national multisectoral coordinating institutions

Table 5.1: GFATM Approvals and World Bank Commitments in Countries Receiving Both (\$US millions)

Country groupings	GFATM approved (2 years)	Total active World Bank commitments (5 years)
African MAP countries, of which:	544.59	959.1
MAP I countries ^a (n = 12)	316.99	462.9
MAP II countries ^b (n = 11)	227.60	496.2
Other countries ^c (n = 13)	200.49	468.7
Total	745.08	1,427.8

Source: GFATM Web site, accessed November 5, 2004.

a. Benin, Burkina Faso, Cameroon, CAR, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Madagascar, Nigeria, Uganda.

b. Burundi, Congo DR, Guinea, Guinea-Bissau, Malawi, Mozambique, Niger, Rwanda, Senegal, Tanzania, Zambia.

c. Bangladesh, Cambodia, Chad, China, Dominican Republic, Guyana, Honduras, India, Jamaica, Moldova, Pakistan, Russian Federation, Ukraine.

Coverage: All countries with approved and signed GFATM proposals for HIV/AIDS and in which the Bank is also providing HIV/AIDS assistance. In instances where several GFATM proposals have been approved, only the value of grant agreements that have been signed are included. GFATM approvals generally include only approvals for HIV/AIDS. The exception is projects labeled HIV/AIDS/TB, where the two parts could not be separated. In these cases the entire amount was attributed to AIDS.

that are in many cases experiencing great difficulty in exercising their basic functions.

The most important partners from the Bank's perspective must remain the developing countries themselves. Efforts to harmonize and collaborate among donors are important to the extent that they are client-oriented and help governments to improve the relevance, efficiency, and efficacy of their response. There remains a risk that harmonization at the country level will expand the scope of activities to include the priorities and monitoring conventions of all donors. This is already the case in the U.N. family: the *Five-Year Evaluation of UNAIDS* concluded that the Integrated Work Plan and U.N. Development Assistance Framework at the

country level “[lack] strategic perspective and are not responsive to country needs” (Poate and others 2002, p. xv).

The Bank is serving its clients best when it exercises its comparative advantage in helping governments to set priorities and sequence activities based on evidence. It can do this through policy dialogue, participatory analytic work, and the design of projects that focus scarce capacity on the highest priority activities—those likely to have the largest impact—with an eye on the sustainability of the response.

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